

		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045674</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																											
Facility Name: <u>Biltmore Rehab and Nursing Ctr</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																											
Address: <u>1701 West 5th Avenue</u> <u>Belvidere</u> <u>61008</u>																													
<div>NumberCityZip Code</div>																													
County: <u>Boone</u>																													
Telephone Number: <u>815-547-5451</u> Fax # (<u> </u>)																													
HFS ID Number: <u>37-1421146</u>		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td colspan="2">(Type or Print Name) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td colspan="2">(Title) _____</td></tr><tr><td colspan="2">(Signed) <u>See Accountant's Report Attached</u></td></tr><tr><td colspan="2">(Date) _____</td></tr><tr><td colspan="2">(Print Name and Title) _____</td></tr><tr><td colspan="2">(Firm Name & Address) <u>Mendel S Schneider & Associates, CPA, PC</u> <u>4556 Oakton St., Ste 200, Skokie, IL 60076</u></td><td colspan="2"></td></tr><tr><td colspan="2">(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u></td><td colspan="2"></td></tr><tr><td colspan="2">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</td><td colspan="2">Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) _____		Paid Preparer	(Title) _____		(Signed) <u>See Accountant's Report Attached</u>		(Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Mendel S Schneider & Associates, CPA, PC</u> <u>4556 Oakton St., Ste 200, Skokie, IL 60076</u>				(Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>				MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001		Phone # (217) 782-1630	
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Date of Initial License for Current Owners: <u>05/29/02</u>																													
Type of Ownership:																													
<table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code _____</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____					
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	<input type="checkbox"/> Trust																												
	<input type="checkbox"/> Other _____																												
In the event there are further questions about this report, please contact: Name: <u>Mendel S Schneider</u> Telephone Number: <u>847-933-1274</u>																													

Facility Name & ID Number Biltmore Rehab and Nursing Ctr

0045674 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>31</u>	Skilled (SNF)	<u>31</u>	<u>11,315</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,885</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,375</u>	<u>150</u>	<u>1,681</u>	<u>3,206</u>	8
9	SNF/PED					9
10	ICF	<u>12,281</u>	<u>2,729</u>		<u>15,010</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,656</u>	<u>2,879</u>	<u>1,681</u>	<u>18,216</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.38%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/29/02

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 05/29/02 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 31 and days of care provided 1,681

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Biltmore Rehab and Nursing Ctr # 0045674 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	125,253	7,741	3,600	136,594		136,594		136,594			1
2	Food Purchase		79,892		79,892	(3,000)	76,892		76,892			2
3	Housekeeping	21,255	37,945	7,795	66,995		66,995		66,995			3
4	Laundry	74,603	8,832		83,435		83,435		83,435			4
5	Heat and Other Utilities			70,900	70,900		70,900		70,900			5
6	Maintenance	27,957		39,214	67,171		67,171		67,171			6
7	Other (specify):*											7
8	TOTAL General Services	249,068	134,410	121,509	504,987	(3,000)	501,987		501,987			8
	B. Health Care and Programs											
9	Medical Director			6,230	6,230		6,230		6,230			9
10	Nursing and Medical Records	778,157	77,595	1,753	857,505		857,505		857,505			10
10a	Therapy											10a
11	Activities	58,571	2,505		61,076		61,076		61,076			11
12	Social Services	33,129		4,886	38,015		38,015		38,015			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	869,857	80,100	12,869	962,826		962,826		962,826			16
	C. General Administration											
17	Administrative	70,279			70,279		70,279		70,279			17
18	Directors Fees											18
19	Professional Services			22,963	22,963		22,963	(5,546)	17,417			19
20	Dues, Fees, Subscriptions & Promotions			22,111	22,111	4,051	26,162	(20,939)	5,223			20
21	Clerical & General Office Expenses	32,010	38,361	32,793	103,164		103,164	(4,075)	99,089			21
22	Employee Benefits & Payroll Taxes			199,031	199,031	(1,051)	197,980		197,980			22
23	Inservice Training & Education											23
24	Travel and Seminar			747	747		747		747			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			74,159	74,159		74,159		74,159			26
27	Other (specify):*											27
28	TOTAL General Administration	102,289	38,361	351,804	492,454	3,000	495,454	(30,560)	464,894			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,221,214	252,871	486,182	1,960,267		1,960,267	(30,560)	1,929,707			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Biltmore Rehab and Nursing Ctr #0045674 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			6,803	6,803		6,803	25,515	32,318			30
31	Amortization of Pre-Op. & Org.			1,055	1,055		1,055	2,761	3,816			31
32	Interest			31,813	31,813		31,813	43,373	75,186			32
33	Real Estate Taxes			20,181	20,181		20,181		20,181			33
34	Rent-Facility & Grounds			78,000	78,000		78,000	(78,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			137,852	137,852		137,852	(6,351)	131,501			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			43,800	43,800		43,800		43,800			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,221,214	252,871	667,834	2,141,919		2,141,919	(36,911)	2,105,008			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,000)	30		9
10	Interest and Other Investment Income	(1,670)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(5,546)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,939)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,615)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,770)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(141)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (141)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (36,911)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

12/31/05

[illegible]

Summary B

12/31/05

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached				Belvidere,LLC	Belvidere	Bldg Rental

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 78,000	Belvidere Care Center, LLC	100.00%	\$	\$ (78,000)	1
2	V	32	Interest		Belvidere Care Center, LLC		45,043	45,043	2
3	V	21	Office		Belvidere Care Center, LLC		540	540	3
4	V	30	Depreciation		Belvidere Care Center, LLC		29,515	29,515	4
5	V	31	Amortization		Belvidere Care Center, LLC		2,761	2,761	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 78,000			\$ 77,859	\$ * (141)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Biltmore Rehab and Nursing Ctr # 0045674 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number (____) _____
Fax Number (____) _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First Equity Bank		X	Mortgage	\$4,807.47	05/23/02	\$ 680,000	\$ 617,470	05/23/07	5.7500	\$ 45,043	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	First Equity Bank		X	Working Capital		05/29/02	255,000	496,547		8.2500	31,813	6	
7												7	
8												8	
9	TOTAL Facility Related				\$4,807.47		\$ 935,000	\$ 1,114,017			\$ 76,856	9	
	B. Non-Facility Related*												
10	Interest Income		X								(1,670)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,670)	14	
15	TOTALS (line 9+line14)						\$ 935,000	\$ 1,114,017			\$ 75,186	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2000		8
2001	29,673	9
2002	18,745	10
2003	19,473	11
2004	20,124	12

Line 4: 20124 x 1.13

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Biltmore Rehab and Nursing Ctr COUNTY Boone

FACILITY IDPH LICENSE NUMBER 0045674

CONTACT PERSON REGARDING THIS REPORT David Abell

TELEPHONE 773-338-4400 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 05-35-409-010		\$ 20,124.34	\$ 20,124.34
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 20,124.34	\$ 20,124.34

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO If so, please complete the following:

1. Total Amount Incurred: 57,241 2. Number of Years Over Which it is Being Amortized: 15 3. Current Period Amortization: 3,816 4. Dates Incurred: 05/29/02

Nature of Costs: Closing Costs (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2002	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9		
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	80		2002		\$ 500,000	\$ 12,820	39	\$ 12,820	\$	\$ 46,474	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Bathroom Remodeling			2002	4,500	115	39	115		350	9	
10	Sign			2002	3,725	96	39	96		323	10	
11	Attic Fans			2002	3,525	90	39	90		311	11	
12	Windows			2002	4,000	103	39	103		339	12	
13	Bathroom Remodeling			2003	4,812	123	39	123		344	13	
14	Fire System Repair			2004	9,844	935	15	935		1,427	14	
15	Remodeling			2005	114,848	4,002	27.5	4,002		4,002	15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$645,254	\$18,284		\$18,284	\$	\$53,570	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 140,339	\$ 18,034	\$ 14,034	\$ (4,000)	10	\$ 49,842	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 140,339	\$ 18,034	\$ 14,034	\$ (4,000)		\$ 49,842	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 835,593	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,318	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 32,318	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,000)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 103,412	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$
- Description:
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	\$
13.	/2007	\$
14.	/2008	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
COMMUNITY COLLEGE
HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM
IN OTHER FACILITY
HOURS PER CNA

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.				
		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (77,091)	\$ (73,538)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	439,158	439,158	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,415	116,415	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	27,853	27,853	8
9	Other(specify): Due from LLC	19,757	24,746	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 526,092	\$ 534,634	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		500,000	14
15	Leasehold Improvements, at Historical Cost	155,593	155,593	15
16	Equipment, at Historical Cost		130,000	16
17	Accumulated Depreciation (book methods)	(14,088)	(148,827)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	15,825	57,241	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(4,220)	(14,197)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 153,110	\$ 729,810	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 679,202	\$ 1,264,444	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 167,799	\$ 167,799	26
27	Officer's Accounts Payable		10,000	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	496,547	496,547	29
30	Accrued Salaries Payable	36,451	36,451	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,198	7,198	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,889	22,889	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 730,884	\$ 740,884	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		617,470	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 617,470	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 730,884	\$ 1,358,354	46
47	TOTAL EQUITY(page 18, line 24)	\$ (51,682)	\$ (93,910)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 679,202	\$ 1,264,444	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (193,852)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (193,852)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	142,170	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 142,170	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (51,682)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Biltmore Rehab and Nursing Ctr # 0045674 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,282,419	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,282,419	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,670	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,670	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,284,089	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	504,987	31
32	Health Care	962,826	32
33	General Administration	492,454	33
	B. Capital Expense		
34	Ownership	137,852	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,141,919	40
41	Income before Income Taxes (line 30 minus line 40)**	142,170	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 142,170	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No,Cash Bas If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 53,201	\$ 25.58	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,261	1,528	35,948	23.53	3
4	Licensed Practical Nurses	13,036	14,296	305,375	21.36	4
5	CNAs & Orderlies	32,909	35,435	374,052	10.56	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,330	4,441	58,571	13.19	10
11	Social Service Workers	2,126	2,174	33,129	15.24	11
12	Dietician					12
13	Food Service Supervisor	1,200	1,200	16,800	14.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,315	12,183	108,453	8.90	15
16	Dishwashers					16
17	Maintenance Workers	2,180	2,257	27,957	12.39	17
18	Housekeepers	2,080	2,211	21,255	9.61	18
19	Laundry	10,133	10,683	74,603	6.98	19
20	Administrator	2,080	2,160	70,279	32.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,103	2,103	32,010	15.22	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	833	835	9,581	11.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	87,666	93,586	\$ 1,221,214 *	\$ 13.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	60	\$ 3,600	1-3	35
36	Medical Director	60	6,230	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	35	1,753	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	96	4,886	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	251	\$ 16,469		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Steven Klekamp	Administrator	0	\$ 48,142	Workers' Compensation Insurance	\$	55,013	IDPH License Fee	\$ 190
Carol Sheperd	Administrator	0	22,137	Unemployment Compensation Insurance		22,045	Advertising: Employee Recruitment	4,051
				FICA Taxes		93,400	Health Care Worker Background Check	
				Employee Health Insurance		24,522	(Indicate # of checks performed)	
				Employee Meals		3,000	Advertising	20,939
				Illinois Municipal Retirement Fund (IMRF)*			Various Subs	837
							Inspections	145
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 70,279					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			Less: Public Relations Expense	
Description			Amount		\$	197,980	Non-allowable advertising	(20,939)
			\$				Yellow page advertising	()
							TOTAL (agree to Sch. V, line 20, col. 8)	
								\$ 5,223
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Mendel S Schneider	Accounting		\$ 10,600				In-State Travel	
Richard Peelo	Accounting		4,200					
Personnel Planners	UC Tax Consultant		1,690					
Larry Schwartz	Legal		764				Seminar Expense	
Meyer Magence	Legal		163				Healthservice Consultant	178
Larry Schwartz	Legal-Adj Out		5,546				Healthcare Information	149
							Various	420
							Entertainment Expense	()
							(agree to Sch. V,	
							line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	TOTAL	\$ 747
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 22,963					

* Attach copy of IMRF notifications

**See instructions.

(See instructions.)

[illegible]

Facility Name & ID Number Biltmore Rehab and Nursing Ctr

0045674

Report Period Beginning: 01/01/05

Ending: 12/31/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 27.5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,500 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,800
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,000 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? No
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.